Today's Date: ______/_______/_______ (MM/DD/YY)

Personal Information

Patient's Full Name: ____

Last *First* *M.I.*

Address: ____

Street Address *Apartment/Unit #*

____

City *State* *ZIP Code*

Home Phone: (   ) ______________________ Cell Phone: (   ) ______________________

E-mail Address: ______________________ Social Security #: ______________________

Birth Date: ____/____/____ Gender: ☐ Male ☐ Female Ethnic Group: ☐ Caucasian ☐ Black ☐ Asian ☐ Hispanic

MM / DD / YY

Emergency Contact Name: ______________________ Emergency Contact Cell Phone: (   ) ______________________

Primary Care Practitioner

Full Name: ____

Last *First* *M.I.*

Address: ____

Street Address *Suite/Unit #*

____

City *State* *ZIP Code*

Office Phone: (   ) ______________________ Office Fax: (   ) ______________________

Cardiologist

Full Name: ____

Last *First* *M.I.*

Address: ____

Street Address *Suite/Unit #*

____

City *State* *ZIP Code*

Office Phone: (   ) ______________________ Office Fax: (   ) ______________________

Electrophysiologist

Full Name: ____

Last *First* *M.I.*

Address: ____

Street Address *Suite/Unit #*

____

City *State* *ZIP Code*

Office Phone: (   ) ______________________ Office Fax: (   ) ______________________

E-mail Address: ____

Pharmacy

Name: ____

Address: ____

Street Address *Suite/Unit #*

____

City *State* *ZIP Code*

Phone: (   ) ______________________ Fax: (   ) ______________________

Referral Source: □ Self Referred □ PCP □ Cardiologist □ EP □ Other ______________

Reason for Consult

In own words:

- Duration of AF?
  - Paroxysmal (comes and goes) ________ Years
  - Continuous (all the time) ________ Years
  - Total number of years with AF ________ Years

History of A Fib

In own words:

- **Your Height: ________ Your Weight: _________**
- Do you have any symptoms when you're in A Fib? □ No □ Yes
  If Yes, describe: ________________________________

  What is your quality of life with AF?: Bad ➔ Fair ➔ Excellent
  (Please circle one number) **1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10**

- Do you have any other Heart Disease? □ No □ Yes
  If Yes, describe: ________________________________
- Do you have any other Medical Problems? □ No □ Yes
  If Yes, describe: ________________________________
- Have you had any Previous Surgeries? □ No □ Yes
  If Yes, Specify: ________________________________
- Previous neurological episode (stroke/TIA)? □ No □ Yes
  If Yes, Specify: ________________________________

==

Have you had?

- Previous Cardioversion? □ No □ Yes If Yes
  Where done & by whom: ______________________
  Date done ___ / ___ / ___ *MM / DD / YY*
- Previous Echocardiogram? □ No □ Yes If Yes,
  Date done ___ / ___ / ___ *MM / DD / YY*
- Previous Stress Test? □ No □ Yes If Yes
  Where done & by whom: ______________________
  Date done ___ / ___ / ___ *MM / DD / YY*
- Previous Cardiac Cath? □ No □ Yes If Yes
  Where done & by whom: ______________________
  Date done ___ / ___ / ___ *MM / DD / YY*
- Previous Ablations? □ No □ Yes
  Where done & by whom: ______________________
  Date done ___ / ___ / ___ *MM / DD / YY*

Social, Family and Allergy History

- Current Alcohol use? □ No □ Yes If Yes # drinks/week = _____
- Tobacco use? □ Yes □ Never used or Stopped ______________ *MM / YY*
  If Yes or stopped ____packs/day X _____ years
- Current/Previous Employment: ____
- Family history of AF? □ No □ Yes
  If Yes specify ____
- Family history of heart disease/heart surgery?
  □ No □ Yes
  If Yes specify ____
- Family history of other serious diseases? □ No □ Yes
  If Yes specify ____
- Allergy to medication or food? □ No □ Yes
  If Yes specify and give type of reaction: ____________________

Medication History

Current Medications:

Medication Name: ________________ Dosage: ________ Frequency: ________________

Reason taking med: ________________________________

Medication Name: ________________ Dosage: ________ Frequency: ________________

Reason taking med: ________________________________

Medication Name: ________________ Dosage: ________ Frequency: ________________

Reason taking med: ________________________________

Medication Name: ________________ Dosage: ________ Frequency: ________________

Reason taking med: ________________________________

Medication Name: ________________ Dosage: ________ Frequency: ________________

Reason taking med: ________________________________

Medication Name: ________________ Dosage: ________ Frequency: ________________

Reason taking med: ________________________________

Previous Antiarrhythmic Medications:

Medication Name: ________________ Reason Discontinued: ________________________

Medication Name: ________________ Reason Discontinued: ________________________

Save this form with your name and send it to kmartinez3@houstonmethodist.org with copy to cmaldonado@houstonmethodist.org. (FirstName_LastName_AFib History Form.pdf)